Road To Healing Counseling
1345 East 3900 South, Suite 104
Millcreek, UT 84124
Tel. 801-441-8943
info@RoadToHealingCounseling.com
www.RoadToHealingCounseling.com

Release of Protected Health Information

Patient information

Name (Last, First, Middle)	Other name(s) used
DOB (mm/dd/yyyy)	Email address
Address (Street, Apt #, City, State, Zip code)	
Work phone	Cell phone

I authorize the following to disclose the individual's protected health information:

Person/Organization Name
Address (Street, Suite #, City, State, Zip code)
Phone

What information can be disclosed? Please initial to indicate those items you approve for disclosure.

	All Health Information		Consultation Results
	Progress Notes		Discharge Summary
	Diagnostic Test Results		Other (describe)

Reason for Disclosure. Initial those areas applicable.

	Treatment/Continuing mental health care		Personal use
	Billing or Claims Insurance		Legal Purpose
	Disability Determination		School
	Employment		Other (describe)

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Who can receive and use the health information?

Person/Organization Name	
Address (Street, Suite #, City, State, Zip code)	
Phone	FAX #

Signature _____ **Date** _____
Signature of Individual or individual's legally authorized representative

Printed Name

_____
Legally authorized representative (if applicable)

Relation to individual _____
Parent, Legal Guardian, Other (specify)

A minor individual's signature is required for the release of certain types of information, including, the release of information related to certain types of reproductive care, sexually transmitted diseases, drug, alcohol or substance abuse, and mental health treatment.

Signature _____ **Date** _____
Signature of minor Individual

Effective time period. The authorization is valid until the earlier occurrence: the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional) **Date** (mm/dd/yyyy) _____

Right to revoke. I understand that I may withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "Who can receive and use the health information". I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

I have read this form and agree to the uses and disclosures of the information described.

Signature _____ **Date** _____
Signature of Individual or individual's legally authorized representative